Disability Management Services, Inc.

1350 Main Street. Springfield, MA 01103-1619 Tel: (413) 747-0990 Fax: (413) 747-1545

A third party administrator for:

Jefferson Pilot Life Insurance Company

Continuance of Disability

TO BE COMPLETED BY THE INSURED

1) Insured's Name:	2) Policy Number(s):	3) Claim number:
CHRIS KEARNEY	H0493029 H053069	

4) Residence address:	5) Telephone number:
621 E. BOWMAN ST. WOOSTER, OH 44691	330-264-4216

6) Describe in detail your typical daily activities:

NO TYPICAL DAY
SLEEP + WORK SOME

7) Have you performed any work since the date of your last report?	8) If "No" state when you expect to resume work:
Yes ✓ No ____	

9) If "Yes", give dates, hours and describe duties performed, along with monthly earnings:

NO MONTHLY EARNINGS SINCE LAST REPORT.
VERY LITTLE WORK DONE.

10) Are you now eligible for, have you applied for, or are you receiving income benefits from:

Social Security(Disability or Retirement Benefits)	Yes ____ No ✓	Workers' Compensation	Yes ____ No ✓
Unemployment Compensation	Yes ____ No ✓	Pension Disability	Yes ____ No ✓
Any Other Disability Income Benefit	Yes ____ No ✓	State Disability Plan	Yes ____ No ✓

11) If "Yes", to any of the items in question #10, please provide details including amounts received, effective dates, and the name of the company, organization, or governmental agency from which benefits are being received:

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is or may be guilty of a criminal act punishable under law.

Signature:	Date:
Christopher Kearney	9-22-01

Please complete your portion of the form on the reverse side and forward the form to your attending physician.

To be completed by the insured

Authorization For Release Of Information:	Signature:	Date:
I hereby authorize the undersigned physician to release any information acquired in the course of my treatment.	Christophe Kearney	9/22/01

To be completed by the attending physician

Dear Doctor:
Please answer all applicable questions below regarding the above mentioned patient.
A return envelope has been provided for your convenience.
Thank you for your prompt cooperation so as to avoid delays in handling this patient's claim.

1) Current Diagnosis:
MMD. depressive features

2) Symptoms observed by physician:
anger, anxiety, sleeplessness, weakness

3) Objective findings: (include date and results of most recent diagnostic tests)
denies S/H / deation
9/15 9/22

4) Dates of treatment within the past three months:
9/15 9/22

5) Briefly describe the current plan of treatment:
support. cognitive structuring
Medication by physician

6) Is the current plan of treatment expected to improve the patient's physical or cognitive function? needs
If so, within what time frame? long term of depression
long term reinforcement, support + TX.

7) Please identify the patients insurance providers for:
Medical Insurance:_____
Disability Insurance:_____
Workers' Compensation:_____
Automobile Insurance:_____

8) Is the patient competent to manage his or her property unassisted, and to understand the nature and consequence of his or her actions, including the ability to endorse checks and direct use of the proceeds? Yes ____ No ____

9) Additional comments or progress:

10) Name of physician:	11) Degree(s):	12) Tax identification number:
Judd McClure	MD	293-34-5458

13) Address:	14) Telephone number:
26700 Goose Creek Rd.	740 - 596 - 3823

15) Signature: Judd McClure MD 16) Date: 9/22/01

d/b/a: New England Claims Administration Services, Inc. in FL, MD, ME
Licensed as New England Claims Administration Services, Inc. in CA.
d/b/a Centre Claims Administration Services in NH